PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Office of the Insurance Commissioner

x **Preproposal Statement of Inquiry was filed as WSR** 12-12-064 **; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR** _____**; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

X **Original Notice**
☐ **Supplemental Notice to WSR** _____
☐ **Continuance of WSR** _____

Title of rule and other identifying information: (Describe Subject) Essential Health Benefits designation, supplementation and establishment of scope and limitation requirements

Insurance Commissioner Matter No. R 2012-17

Hearing location(s):
Training Room, T-120
5000 Capitol Way S
Tumwater Washington

Date: October 23, 2012 Time: 10:00 a.m.

Date of intended adoption: November 1, 2012
(Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: Meg L. Jones
Address: P.O. Box 40258
Olympia WA 98504
e-mail rulescoordinator@oic.wa.gov
Fax: 360-586-3109 by (date) October 24, 2012

Assistance for persons with disabilities:

Contact Lorrie Villaflores by October 22, 2012
TTY (360) 586-0241 or (360) 725-7087

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The proposed rules do not alter existing rules. The proposed rules establish the essential health benefits package for Washington State's non-grandfathered individual and small group plans, and explain the proposed standards the commissioner will apply for evaluating whether a carrier's proposed plan complies with the requirements of both federal and state law to include the essential health benefits package in the health benefit plan.

Reasons supporting proposal:
Legislation enacted during the 2012 session directs the Commissioner to designate by rule the small group plan with the largest enrollment, as the benchmark plan for purposes of defining the essential health benefits package for health benefit plans issued between January 1, 2014 and December 31, 2015. The same legislation requires supplementation, and adjustment or establishment of scope and limitation requirements by the commissioner in order to ensure meaningful benefits and prevent bias based on health selection.

Statutory authority for adoption: chapter 87, laws of 2012; RCW 48.02.060

Statute being implemented: chapter 87, laws of 2012

Is rule necessary because of a:

Federal Law?	☐ Yes	x No
Federal Court Decision?	☐ Yes	x No
State Court Decision?	☐ Yes	x No

If yes, CITATION:

DATE
September 19, 2012

NAME (type or print)
Mike Kreidler

SIGNATURE

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 19, 2012
TIME: 11:54 AM

WSR 12-19-101

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Name of proponent: (person or organization) Office of the Insurance Commissioner

☐ Private
☐ Public
x Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Meg Jones	P.O. Box 40258, Olympia WA 98504	(360) 725-7170
Implementation....	Beth Berendt	P.O. Box 40258, Olympia WA 98504	(360) 725-7117
Enforcement.....	Carol Sureau	P.O. Box 40258, Olympia WA 98504	(360) 725-7050

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( ) _____
fax ( )_____
e-mail _____

X No. Explain why no statement was prepared.

The entities that must comply with the proposed rule are not small businesses, pursuant to chapter 19.85 RCW.

Is a cost-benefit analysis required under RCW 34.05.328?

X Yes A preliminary cost-benefit analysis may be obtained by contacting:
Name: Meg Jones
Address: P.O. Box 40258
Olympia WA 98504

phone (360) 725-7170
fax (360)586-3109
e-mail rulescoordinator@oic.wa.gov

☐ No: Please explain:

NEW SECTION

WAC 284-43-851 Purpose and Scope For plan years beginning on or after January 1, 2014, each non-grandfathered health benefit plan offered, issued, amended or renewed to small employers or individuals, both inside and outside the Washington Health Benefit Exchange, must provide coverage for a package of essential health benefits. Sections WAC 284-43-851 through WAC 284-43-885 implement the requirements of section 13, chapter 87, laws of 2012, establishing a benchmark reference plan and the essential health benefit package required in Washington State for non-grandfathered individual and small group health benefit plans.

(1) The commissioner will implement this sub-chapter to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits.

(2) This sub-chapter does not apply to a health benefit plan that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21), or a health benefit plan that qualifies as a grandfathered health plan as defined in RCW 48.43.005, unless a plan is providing an essential health benefit for pediatric oral services or vision services within the exchange, or as a subcontractor to a health benefit plan.

(3) This sub-chapter does not require provider reimbursement at the same levels negotiated by the benchmark reference plan's carrier for their plan.

(4) This sub-chapter does not require a plan to exclude the services or treatments from coverage that are excluded in the benchmark reference plan.

NEW SECTION

WAC 284-43-852 Definitions The following definitions apply to this sub-chapter unless the context indicates otherwise.

(1)"Benchmark reference plan" means the small group plan offered in the state with the largest enrollment, as designated in WAC 284-43-865 (1).

(2) "Individual plan" includes any non-grandfathered health benefit plan offered, issued, amended or renewed by an admitted carrier in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to a master contract held by an

organization determined to be a bona fide association by the united states department of labor.

(3) "Mandated benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that is required by either state or federal law.

(4)"Meaningful health benefit" means the range of services or benefits within each of the ten essential health benefit categories identified in section 1302 of PPACA that are necessary to ensure enrollees covered access to clinically effective services, including services critical to the needs of those with chronic disease or those with special needs based on age or gender.

(5) "Medical necessity determination process" means the process used by a health carrier to make a specific type of coverage determination about whether a medical item or service, which is a covered benefit, is medically necessary for an individual patient's circumstances.

(6) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(7) "Scope and limitation requirements" means a requirement applicable to a benefit that limits the duration of a benefit, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility limitation on a specific benefit.

(8)"Small group plan" includes any non-grandfathered health benefit plan offered, issued, amended or renewed by an admitted carrier in the state of Washington for the small group health benefit plan market to a "small group," as defined in RCW 48.43.005, unless the certificate of coverage is issued to a small group pursuant to a master contract held by or issued through an entity meeting the definition established in sections 3(5) and 3(40) of the Employee Retirement Income Security Act of 1974(29 USC 1001 et seq.)

(9) "Stand-alone dental" means a contract or coverage plan covering a set of benefits limited to oral care, including but not necessarily limited to, pediatric oral care.

(10)"Supplemental Benefit" means a health care service, benefit or supply designated by the commissioner to supplement the benchmark reference plan in one of the essential health benefit categories.

NEW SECTION

WAC 284-43-860 Supplementation of Essential Health benefits The commissioner may supplement the benchmark reference plan coverage and may adjust or establish scope and limitation requirements for services, supplies or benefits within each essential health benefit category, based on the criteria identified in this section. The scope requirements include establishing the definition for the essential health benefit category.

(1)Supplementation of the benchmark reference plan is based on one or more of the following criteria:

(a)Whether a specific essential health benefits category required by PPACA is missing in its entirety;

(b) Whether the benchmark reference plan's specifically identified coverage provides the benefits or services necessary to address the medical concerns of greatest importance to enrollees;

(c) Whether the benchmark reference plan's coverage in an essential health benefits category is unduly limited so as to constitute an unreasonable restriction on patient treatment, or an illusory or deceptive benefit;

(d)Whether the benchmark reference plan includes a service or benefit that addresses the medical concerns of greatest importance to effective chronic disease management or the particular needs of the most vulnerable patients and populations;

(e) Whether the services or benefits designated to supplement the benchmark reference plan are medically effective and supported by a sufficient evidence base or a credible standard that demonstrates the probability of meaningful improvement in outcomes over current effective services/treatments and for which the expected benefits are greater than the expected harms;

(f) Whether the benchmark reference plan's specifically identified services and benefits include a full continuum of effective, integrated treatment practices within an essential health benefit category; and

(g) The potential effect of supplementing the essential health benefit category on the cost of coverage, particularly for those with incomes at or above 400% of the federal poverty level.

(2) Adjustment to the scope and limitation requirements in the benchmark reference plan is based on one or more of the following criteria:

(a) Whether the scope of a benefit covered by the benchmark reference plan in an essential health benefits category is unduly limited so as to constitute an unreasonable restriction on patient treatment, or an illusory or deceptive benefit;

(b)Whether the scope or limitation requirement for a benefit covered by the benchmark reference plan in an essential health benefits category impermissibly discriminates based on health status or other basis prohibited by federal or state law;

(c) Whether the scope or limitation requirement, or the coverage in the benchmark reference plan under an essential health benefit category, is more restrictive or limited than the benefits under the state Medicaid coverages; or

(d) Whether the cost of the service or benefit in an essential health benefit category would, more probably than not, substantially affect the affordability of the coverage in the absence of the imposition of a scope or limitation requirement, and whether such scope or limitation requirement permits the benefit to continue to meet the supplementation criteria.

(3) A carrier must not apply annual or lifetime financial limits to any service or benefit included in the essential health benefits package.

NEW SECTION

WAC 284-43-870 List of Supplemented Benefits and Scope and Limitation requirements A non-grandfathered individual or small group health plan offered, issued, amended or renewed on or after January 1, 2014 must include the supplemental benefits, and cover them based on the scope requirements established by the commissioner for the category in which they are classified, in addition to the benefits in the designated benchmark reference plan.

(1)The list of benchmark reference plan benefits, with services classified under an essential health benefits category, is posted on the insurance commissioner's website, www.insurance.wa.gov.

(2)The required list of supplemental benefits, classified under an essential health benefit category, is posted on the insurance commissioner's website, www.insurance.wa.gov.

(3)Any adjustment by the commissioner to the posted list of supplemented benefits or the scope and limitation requirements will be made pursuant to a rule proposal and development in compliance with chapter 34.05 RCW.

NEW SECTION

WAC 284-43-875 Scope and Limitation Requirements

(1) A carrier may not apply its medical necessity determinations in a manner that results in a uniformly applied limitation on the scope, visit number or duration of a benefit that applies regardless of the specific treatment requirements of the patient, unless that uniform limitation is specifically explained in the certificate of coverage, plan document or contract, and the Summary of Coverage and Explanation of Benefits for the health plan.

(2) Scope and duration limits for purposes of this section do not include cost-sharing provisions.

(3) The scope and limitation requirements for specific services and benefits, and the definition of each essential health benefit category are posted on the insurance commissioner's website, www.insurance.wa.gov.

(4) A carrier's medical necessity determination process must:

(a) Be clearly explained in its certificate of coverage, plan document or contract for health benefit coverage;

(b) Conducted fairly, and with transparency, at a minimum when an enrollee or their representative appeals or seeks review of an adverse benefit determination;

(c) Include consideration of services that are less costly, less risky and a logical next step in reasonable care if they are appropriate for the patient, even if the service has not been the subject of clinical studies;

(d) Ensure that its process for interpretation of the medical purpose of interventions is broad enough to address the services encompassed in the ten essential health benefits categories of care;

(e) Comply with state and federal requirements for the inclusion of the ten essential health benefit categories of care, and prohibitions against discrimination based on age, disability, and expected length of life; and

(f) Consider the provider's clinical judgment and recommendations regarding the medical purpose of the requested service, and the extent to which the service is likely to produce incremental health benefits for the enrollee.

(5) A carrier's medical necessity determination process may include, but not be limited or required to include, evaluation of the effectiveness and benefit of a service for the individual patient based on scientific evidence considerations, up-to-date and consistent professional standards of care, convincing expert opinion and a comparison to alternative interventions, including

no interventions. Cost effectiveness may be criteria for determining medical necessity if it is not limited to "lowest price."

NEW SECTION

WAC 284-43-880 Plan Design Parameters (1) A non-grandfathered health benefit plan issued, renewed, amended or offered on or after January 1, 2014 must cover the ten essential health benefits categories as set forth in the benchmark reference plan, as supplemented by the commissioner, at least to the extent that the benefits and services included are medically necessary, and so that the benefits are substantially equal to the designated benchmark plan, as supplemented.

For the purposes of this section "substantially equal" means that the scope and level of benefits offered within each essential health benefit category is meaningful, and the aggregate value of the benefits across all essential health benefit categories, and within each essential health benefit category, is not less than the aggregate value and each category's value of the benchmark reference plan as supplemented by the commissioner.

(2) A carrier may not alter its health benefit plan design by transferring a service from the category assigned to it by the commissioner in WAC 284-43-875 if that transfer results in the elimination of a parity requirement.

(3) Nothing precludes a health carrier from including benefits in a health benefit plan that are in addition to the benchmark reference plan's essential health benefit package, as supplemented by the commissioner. A carrier must identify in its rate filing services substituted within a category as part of the essential health benefits package if the carrier includes the service in calculating actuarial value of the essential health benefits package.

(4) To the extent that the benchmark reference plan contains benefit limitations that conflict with requirements of PPACA, the benefit limitations must be amended to comply with PPACA's requirements.

(5) A health benefit plan may not be offered if the commissioner determines that:

(a) It creates a risk of biased selection based on health status; or

(b) The benefits within an essential health benefit category are not a meaningful benefit.

(6) A carrier may not apply deductible requirements to evidence based preventive health services covered by a health benefit plan, including those that have an A or B rating in the most recent recommendations of the United States Preventive Services Task Force, women's preventive healthcare services recommended by the U.S. Health Resources and Services Administration (HRSA), and HRSA Bright Futures designated pediatric services.

(7) Pediatric oral benefits must be included in a health benefit plan either as an embedded set of services, offered through a rider or as a contracted service.

NEW SECTION

WAC 284-43-882 Consistency of Coverage (1) A carrier may adjust limitation requirements for identified services or benefits within an essential health benefits category only if the actuarial value of the services and benefits within that essential health benefits category remains unchanged.

(a) In addition to confirming that a limitation requirement has not changed the actuarial value of an essential health benefit category, a carrier may not make the adjustment if the commissioner finds that, after the adjustment, the essential health benefit category no longer constitutes a meaningful benefit.

(b) Services may be offered under more than one category, but for purposes of determining the actuarial value for one on the ten essential health benefit categories, a carrier must include an enumerated service in its designated category for purposes of the calculation.

(2) Carrier adjustment of a limitation requirement must not violate other requirements of title 48 RCW, title 284 WAC, or P.L. 111-148 (2010), as amended, and associated regulations, bulletins and guidance issued by the u.s. department of health and human services.

(3) A carrier must not impose annual or lifetime dollar limits on an essential health benefit.

(4) At the time a health benefit plan form is filed with the commissioner for approval, if a carrier elects to adjust specific services within any of the essential health benefit categories, or the quantitative limits for a service, a carrier must submit with its filing an actuarial opinion certifying the equivalence of the value of the plan's essential health benefits

in the category, and overall, to the benchmark reference plan as supplemented.

(5)A health benefit plan that includes the essential health benefits package may not impose annual cost-sharing that exceeds the limits that apply to high deductible plans linked to health savings accounts.

(a)For the 2014 benefit year, those limits are $5,950 per year for individuals and $11,900 per year for families for individual health plans including the essential health benefits.

(b)For the 2014 benefit year, a small group health benefit plan including the essential health benefits must limit deductibles to $2,000 for individual coverage and $4,000 for family coverage.

(c)The commissioner will publish on the agency website adjusted cost sharing limits for subsequent benefit years if those limits are altered at the federal level.

NEW SECTION

WAC 284-43-885 Representations regarding Minimum Essential Coverage A health carrier must not indicate or imply that a health benefit plan covers essential health benefits unless the plan covers essential health benefits in compliance with this sub-chapter. This requirement applies to any health benefit plan offered inside or outside the Washington Health Benefit Exchange.